kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

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Money Follows the Person: A 2011 Survey of Transitions, Services and Costs

EXECUTIVE SUMMARY

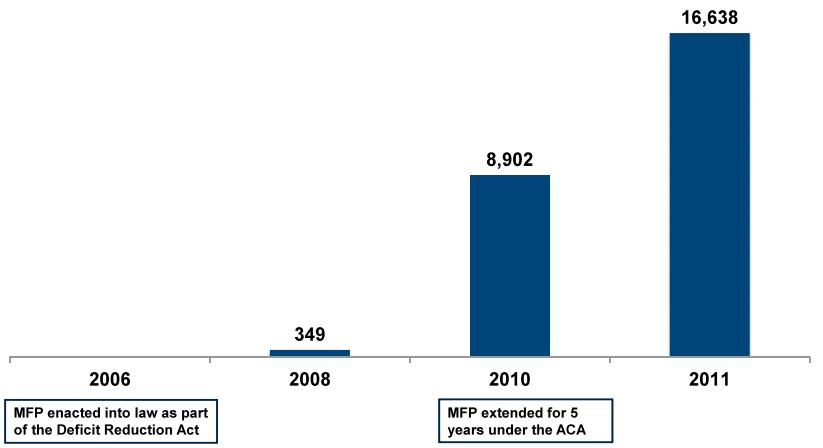
A total of 44 states, including the District of Columbia, have received federal grant money to transition Medicaid beneficiaries out of institutions and back to their homes or the community through the Money Follows the Person (MFP) demonstration. Enacted into law in 2006 as part of the Deficit Reduction Act (DRA) and extended under the Affordable Care Act (ACA), MFP offers states the opportunity to receive enhanced federal matching funds for twelve months for each Medicaid beneficiary that transitions back to a community setting. Over the past year, thirteen states have applied and received funding to begin a MFP demonstration joining the 30 states currently operating MFP demonstration programs. In August 2011, the Kaiser Commission on Medicaid and the Uninsured (KCMU) surveyed states about the current status of their MFP demonstrations inquiring about trends in enrollment, services and per capita spending. This year's annual survey highlights findings based on responses from all 44 MFP states.

Key Findings:

As of August 2011, nearly 17,000 individuals have transitioned back to the community and another 5,700 transitions are currently in progress. Three states (Ohio, Texas and Washington) made up nearly half (46%) of all MFP transitions. The majority of MFP transitions to date have been individuals with physical disabilities and seniors. Individuals with mental illness and developmental disabilities are less likely to be candidates for transition due to their extensive health and long-term services needs. States have been making steady progress over the past three years in enrolling MFP participants, after a slow start to the program due to implementation delays and challenges related to transitioning populations with multiple chronic health conditions. A year ago, states reported transitioning 8,900 individuals back to the community up from just 349 individuals in 2008 (Figure 1). On average, MFP participants were 50 years old, took 4.6 months to transition home and most often transitioned to an apartment setting. States also reported an 8.3 percent reinstitutionalization rate across all populations.

Figure 1

Money Follows the Person Cumulative Transitions



Note: In 2008, 30 states and DC had MFP demonstrations. In 2011, 13 new states received MFP funding
SOURCE: KCMU surveys of state MFP demonstration programs in 2008, 2010 and 2011.

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States provided a comprehensive set of benefits, including those provided under existing home and community-based (HCBS) waivers and state plans, demonstration services, and supplemental services, to ensure successful transition back to the community. In addition to offering HCBS waiver services that continue once the 365-day MFP demonstration program ends, 29 states reported offering demonstration services to MFP participants. Demonstration services are services that can be covered under Medicaid and funded at the enhanced MFP FMAP during the individual's 12-month transition period, but after the demonstration period ends, the state is not obligated to continue these services. Eighteen states reported offering supplemental services that are not necessarily long-term care in nature, but are one-time transition costs or services only offered during the demonstration and are reimbursed at the state's regular FMAP rate.

The average monthly cost of serving a MFP participant in the community was roughly $9,400 per person. In comparison, the national average per person spending on Medicaid HCBS only, including HCBS 1915(c) waivers, the home health and the personal care services benefit but not other Medicaid-covered services, was $14,665 in 2008. Average monthly costs were highest for individuals with developmental disabilities ($7,636) followed by individuals with physical disabilities ($3,489) and seniors ($2,130). When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions with MFP participants, the majority of states said MFP per capita costs were lower. When asked to compare MFP costs with costs for other Medicaid HCBS beneficiaries, thirteen states said costs were comparable, two states said costs were lower and two states said per capita costs were higher.

Housing and workforce capacity are among the major challenges facing MFP demonstrations in the year ahead but states are moving ahead with ACA options to expand Medicaid HCBS. States highlighted the importance of partnering with local public housing authorities and employing housing coordinators within MFP as key factors to providing safe, accessible, and affordable housing options. States stressed the need for additional funding assistance related to housing noting that long wait lists for housing support vouchers often delay transitions. About half of MFP states reported an inadequate supply of direct care workers in the community, especially in rural areas. Despite these challenges, twenty-eight MFP states are planning to take up at least one of several new ACA options to expand Medicaid home and community-based services. The most popular new option reported was the Health Home option (17 states) for the chronically ill that offers a new approach to manage care.

Conclusion

Over the past three years, states have transitioned a cumulative total of nearly 17,000 individuals out of institutional settings and back home to the community. Although it took most MFP states several years to become operational, 2011 marked a turning point for MFP. Thirteen new states took advantage of extended funding to begin MFP demonstrations, making a total of 44 states that have received MFP funds to date. As states embrace rebalancing their long-term services and supports delivery systems, MFP will remain a critical program helping to change the way long-term services and supports are delivered. With the help of critical services such as transition coordination, assistive technology, and affordable housing options, many more people will benefit from MFP in the years ahead. However, as more Medicaid beneficiaries are identified to transition to the community, and as the population continues to age, more attention to workforce and housing options will be important to help facilitate successful community placements.

INTRODUCTION

The Money Follows the Person (MFP) demonstration grant program was authorized by Congress as part of the 2005 Deficit Reduction Act (DRA) and provides states with enhanced federal matching funds for twelve months for each Medicaid beneficiary transitioned from an institutional setting to a community-based setting. Qualified community settings include a home, apartment, or group home with less than four non-related individuals residing in it. The enhanced federal support is designed to encourage state efforts to reduce reliance on institutional care for individuals needing long-term services and supports and expands options for individuals with disabilities and the elderly who wish to receive services in the community.

The Kaiser Commission on Medicaid and the Uninsured (KCMU) conducted a survey of state MFP project directors in 2008 and 2010 to gauge the progress states made in transitioning individuals back home. As of September 2010, 30 states had transitioned nearly 9,000 individuals back to the community. While some MFP programs became operational in 2007, the majority of transitions occurred between 2008 and 2010 because states took some time to get their programs up and running. Individuals benefiting from the MFP demonstration included seniors, persons with intellectual, developmental and/or physical disabilities, mental illness and those diagnosed with multiple chronic and disabling conditions. The major challenges facing MFP states in 2008 were finding safe, affordable, and accessible housing and gaining CMS approval of states' operational protocols. Last year's 2010 MFP survey found significant gains in the number of transitions and nearly 4,000 transitions in progress. However, states were still struggling with a shortage of affordable housing, a poor economic climate and a weak community-based services and supports infrastructure. Efforts underway to address these challenges included forming strategic partnerships with housing authorities and identifying the necessary tools and training to support direct service workers.

Over the past year, thirteen states have applied and received funding to begin a MFP demonstration. Under the Affordable Care Act (ACA), MFP was extended five years through 2016 and an additional $2.25 billon was targeted to the demonstration. The ACA also made changes to MFP eligibility. Under the ACA, individuals that reside in an institution for more than 90 consecutive days are now eligible to participate. The previous residency period was from six months to two years. However, days that an individual resides in an institution for the sole purpose of receiving short-term rehabilitation under Medicare cannot count for the 90-day period required for MFP eligibility. In last year's survey, the majority of states reported this policy change would increase the number of future MFP participants.[1]

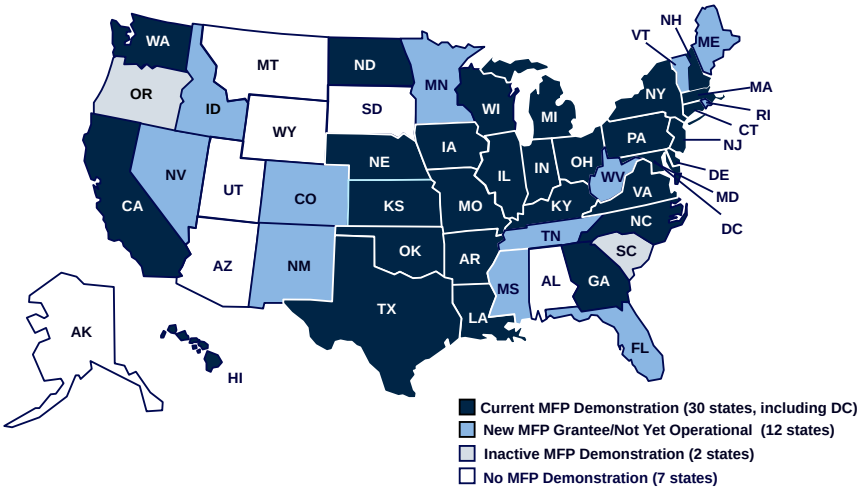
Methodology – This report is based on a KCMU survey of state MFP programs conducted in August 2011. The survey was designed to obtain information on MFP enrollment, services and per capita costs in each state. We also asked states to respond to questions about the role of self-direction in MFP, the adequacy of community-based providers in their state, the current economic environment and the impact of new health reform options on Medicaid home and community-based services. At the time of the survey, a total of 30 states had operational programs, 12 states were at varying degrees of becoming operational within the next year, and

[1] Molly O'Malley Watts, Money Follows the Person: A 2010 Snapshot, Kaiser Commission on Medicaid and the Uninsured, February 2011, http://www.kff.org/medicaid/upload/8142.pdf.

two states had suspended their current programs (OR, SC) (Figure 1). Previous year's surveys can be found at http://www.kff.org/medicaid/8142.cfm and http://www.kff.org/medicaid/7928.cfm. The data for this report was provided directly from state officials in response to a written survey. The full survey instrument can be found in Appendix A of this report. Survey responses were received from all 44 MFP grantee states. New grantee states that had yet to reach operational status responded to as many of the survey questions as possible, based upon their operational protocol submitted to CMS. Several new grantee states were still in the process of hiring a MFP project director and were not able to provide significant detail on their demonstration.

Figure 1

Money Follows the Person Demonstration Program Status, as of August 2011



SOURCE: KCMU survey of state MFP demonstration programs, as of August 2011.

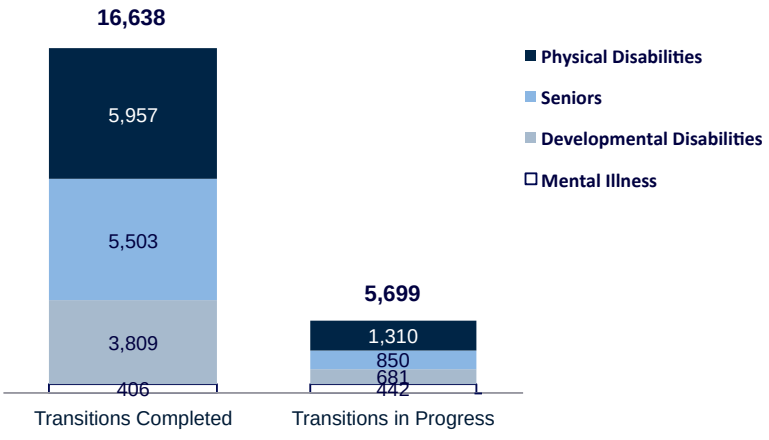
KEY FINDINGS

Enrollment

As of August 2011, nearly 17,000 individuals have transitioned back to the community and another 5,700 transitions are currently in progress (Figure 2). Texas had the highest number of cumulative transitions (4,685) and Delaware had the fewest (52). Three states (Ohio, Texas and Washington) made up nearly half (46%) of all MFP transitions. Variation in program size reflects, among other things, the length of program operation, the size of the

Figure 2

Distribution of MFP Transitions, by Target Population



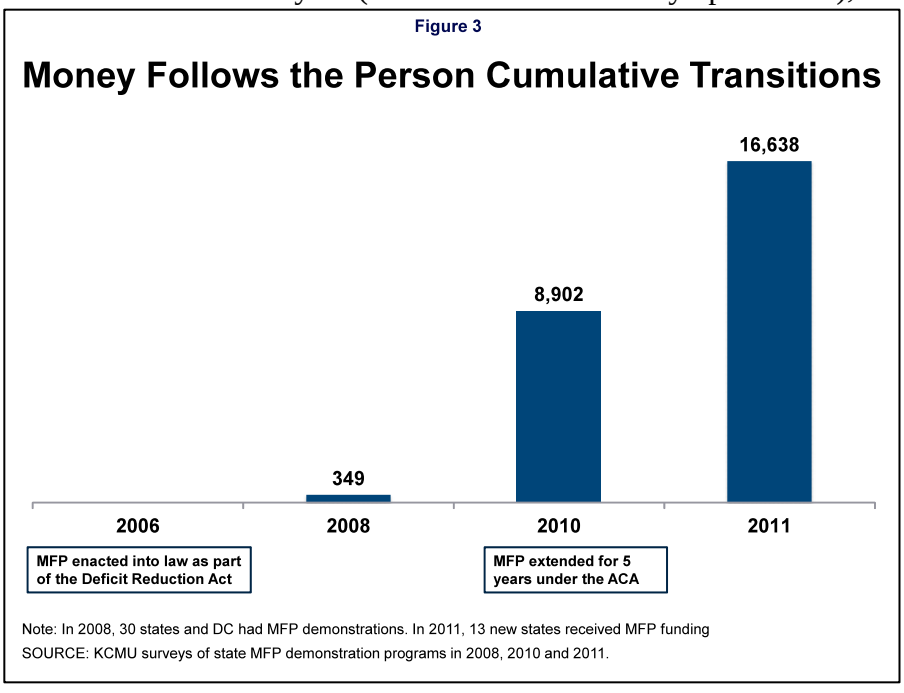
NOTE: The total number of transitions completed includes 963 individuals (and 3,283 transitions in progress) from states that did not specify target population in their survey response.

SOURCE: KCMU survey of state MFP demonstration programs, 2011.

eligible population in each state, and state capacity and experience in operating transition programs of this type.[2] The majority of MFP transitions to date have been individuals with physical disabilities (36%) and seniors (33%). Individuals with mental illness and developmental disabilities are less likely to be candidates for transition due to their extensive health and long-term services needs. However, a number of states (24 states) have taken steps to increase the number of transitions among the mentally ill population. For example, three states mentioned trying to increase the number of transitions of children under age 22 living in institutions for mental disease (IMDs). Other states reported looking into using the 1915(i) state plan option to target individuals with mental health needs capable of moving back to the community and increasing the number of 1915(c) waivers that target individuals with mental illness. New Hampshire has hired a behavioral health transitional coordinator to work closely with specific nursing institutions and facilities that treat individuals with mental illness. Several MFP officials noted their ongoing partnerships with the state Mental Health Agency and state behavioral health staff as critical to identifying and successfully transitioning more individuals with mental illness in the future.

States have made significant progress over the past three years enrolling MFP participants, after a slow start to the program due to implementation delays and challenges related to transitioning populations with multiple chronic health conditions. A year ago, states reported transitioning 8,900 individuals back to the community up from just 349 individuals in 2008 when states were just beginning to implement their MFP demonstrations (Figure 3). To date, a total of 30 states with operational programs have transitioned nearly 17, 000 MFP participants with another 5,700 transitions currently in progress. In 2010, states reported 4,000 transitions in progress, up from just 465 transitions in progress in 2008. Looking ahead, 12 new grantee states plan to be operational over the next year (Massachusetts is already operational), increasing the opportunity to serve more Medicaid beneficiaries in home and community-based settings.

Figure 3



This year's survey was expanded to include questions related to characteristics of MFP participants. State officials were asked to report the average age of MFP participants, average time to transition out of an institutional setting, the

[2] Mathematica Policy Research, Inc. Money Follows the Person Demonstration: Overview of State Grantee Progress July-December 2010, May 2011, available at http://www.mathematica-mpr.com/publications/PDFs/health/MFP_july-Dec2010_progress.pdf.

residential housing option most often used by MFP participants, and the average rate of reinstitutionalization. Where possible, states were asked to include responses by target population. State officials reported the following results:

- **The average age of MFP participants was 50 years old;**
- **MFP participants averaged 4.6 months to transition back to the community;**
- **MFP participants most often transitioned to an apartment; and**
- **The average reinstitutionalization rate was 8.3 percent.**

Looking across all target populations, results varied. MFP participants with a physical or developmental disability or a mental illness were more likely to be under age fifty. The average age of seniors transitioning home was seventy-one. Seniors were more likely to transition back to their own homes or a family member's home, whereas individuals with developmental disabilities more often relied on small group homes for their housing option. States reported an 8.3 percent reinstitutionalization rate across all populations. Reinstitutionalization is defined as those who returned to a nursing home, hospital, or ICF-MR, regardless of length of stay. In 2010, states reported only 300 individuals returning to an institutional setting, but not all states responded to this survey question or reported keeping track of this rate. States are now required to report reinstitutionalization data in their progress reporting system to CMS.

Within a state, outreach and enrollment efforts are often accomplished through partnerships with the Medicaid program and other state agencies, community stakeholders and MFP staff. The ACA appropriated $10 million a year for five years from 2010 to 2014 to expand Aging and Disability Resource Centers to serve as community access points for individuals seeking long-term services and supports. Thirty-four states reported partnering with ADRCs to assist with referrals and to help coordinate transitions. ADRC coordinators that receive funding from MFP can assist with registration, MFP program eligibility verification, and waiver allocation distribution to prospective MFP participants. Most states expect increased referrals to MFP due to implementation of the Minimum Data Set (MDS) Section Q questions regarding nursing home residents' desire to return to the community.

Despite progress in enrollment, states are still far from reaching their original goal of transitioning nearly 38,000 individuals back to the community. Since that time, a number of challenges have arisen which resulted in states scaling back their original enrollment projections. A more accurate reflection of state's transition goals can be found in their annual data reporting to CMS. We also asked states to report whether they were on pace with annual transition targets and most (25 states) reported that they were on target to meet annual goals.[3] Ten states reported that they were not on pace to meet their annual projections due to a number of challenges including: lack of affordable, accessible housing options, inadequate supply of community

[3] Starting in 2011, CMS revised its policy to begin holding states accountable for meeting their transition goals. CMS can withhold the disbursement of MFP grant funds for those states falling far short of their transition goals. As a result, many states reduced their annual transition goals for 2010 and subsequent years. "Money Follows the Person Demonstration: Overview of State Grantee Progress, July-December 2010," Mathematica Policy Research, Inc., May 2011.

providers, and restrictions on the use of qualified housing options related to small group homes (four people or less) and assisted living facilities.

Benefits

States provide a comprehensive set of benefits to MFP participants, including those provided under existing HCBS waivers and state plans amendments, MFP demonstration services, and supplemental services, to ensure successful transition back to the community. Qualified HCBS services are HCBS waiver services that will continue once the MFP demonstration program has ended. Common benefits included under Medicaid HCBS waivers are: case management, homemaker services, home health aide services, personal care, adult day health care, habilitation, and respite care. Demonstration services are services that can be covered under Medicaid and funded during an individual's 12-month transition period. After the demonstration period ends, the state is not obligated to continue the MFP demonstration services, but may choose to fund them through Medicaid at the regular match rate for eligible individuals. HCBS and demonstration services are reimbursed at the enhanced MFP FMAP. Twenty-nine states reported offering demonstration services to MFP participants in addition to HCBS waiver and state plan services.

Supplemental services are not long-term care in nature, but are one-time transition costs or services only offered during the demonstration and are reimbursed at the state's regular FMAP rate. States gear the benefits offered under MFP demonstration and supplemental services toward ensuring successful transition back to community living. These services include transition coordination, one-time housing expenses (such as security deposits, utility deposits, furniture and household set up costs), assistive technology, employment skills training, 24-hour back-up nursing, home delivered meals, peer community support, and ombudsman services. Eighteen states reported offering supplemental services.

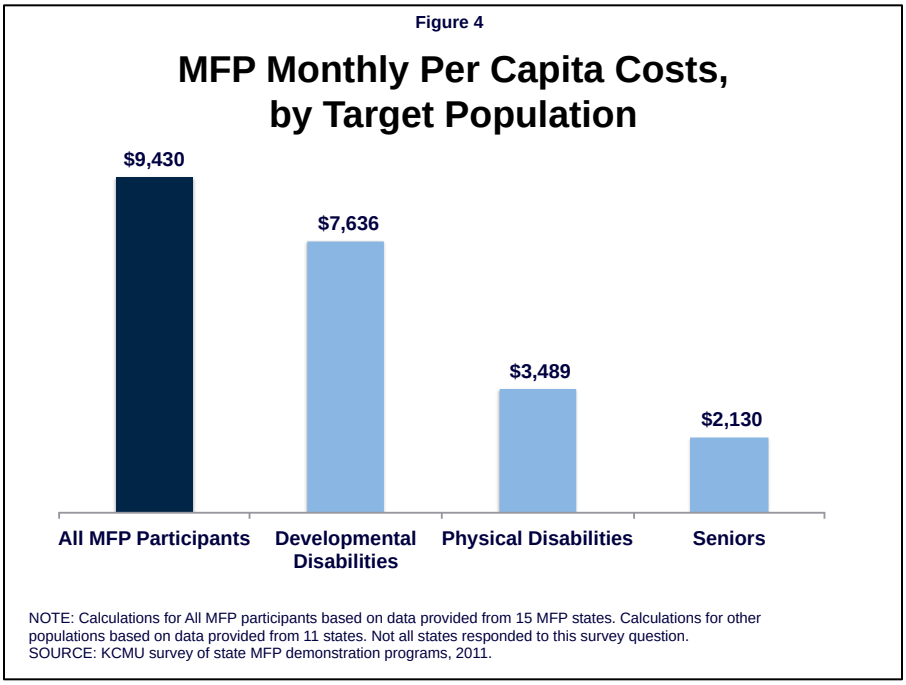
Many of the services offered under MFP are geared toward the complex health and physical limitations of Medicaid beneficiaries. For example, several states offer non-medical transportation services designed to not only help individuals get to and from doctors appointments but also to help them go shopping and run errands they would not be able to do on their own. Other notable services are as follows: personal emergency response systems, trial overnights with ICF/MR staff; and employment skills training to ensure individuals not only transition home safely but also have the skills to work if they so desire.

Self-direction is an option in most state's MFP programs, although the percentage of MFP participants who opt to self-direct is low. Thirty-three states offer or have plans to offer Medicaid beneficiaries the authority to make decisions over some or all of their services. Only six states responded that self-direction was not a component of their MFP demonstration. Self-direction is an alternative to provider management of services wherein a service provider has the responsibility for managing all aspects of service delivery. Self-direction promotes personal choice and control over the delivery of services, including who provides services and how they are delivered. For example, the MFP participant may be given the opportunity to recruit, hire, and supervise direct service workers. States estimated that 12 percent of MFP participants self-direct some of their own services. Three states reported nearly 100% participation in self-direction (CA, DE, OH) due to the fact that one-time home setup funding is counted as a self-directed service.

Financing

The average monthly cost of serving a MFP participant in the community was roughly $9,400 per person (Figure 4). States were asked to report average monthly per capita costs of MFP participants and amounts ranged from a high of $28,526 to a low of $1,625 per person per month, based on responses from 15 states. In comparison, the national average per person spending on Medicaid HCBS only, including HCBS 1915(c) waivers, the home health and the personal care services benefit but not other Medicaid-covered services, was $14,665 in 2008, with great variation among states and across programs.[4] As with HCBS waiver expenditures, states that transitioned a greater number of individuals with developmental disabilities had higher per capita costs since these individuals have extensive health and long-term services needs. Average monthly costs were highest for individuals with developmental disabilities ($7,636) followed by individuals with physical disabilities ($3,489) and seniors ($2,130).

Figure 4



NOTE: Calculations for All MFP participants based on data provided from 15 MFP states. Calculations for other populations based on data provided from 11 states. Not all states responded to this survey question.
SOURCE: KCMU survey of state MFP demonstration programs, 2011.

When asked to compare the cost of serving Medicaid beneficiaries who reside in institutions with MFP participants, 18 states said MFP per capita costs were lower. Only two states reported that the costs were comparable and no state said they were higher. When asked to compare MFP costs with costs for other Medicaid HCBS beneficiaries, responses were split. Thirteen states said costs were comparable, two states reported higher MFP per capita costs, and two states reported lower costs. The remaining states were either unsure of an answer or did not answer the survey question.

ISSUES FACING MFP IN 2011 AND BEYOND

Twenty-nine states highlighted the importance of partnering with local public housing authorities as a key factor to providing safe, accessible, and affordable housing options. Since we began surveying states in 2008, states have consistently reported challenges finding safe, affordable housing and these challenges continue for MFP officials and beneficiaries today.

[4] Terence Ng et al, Medicaid Home and Community-Based Service Programs: Data Update, Kaiser Commission on Medicaid and the Uninsured, December 2012.

States acknowledged the need to be aware of housing resources, funding availability for environmental modifications, and partnerships with other state, local and non-profit organizations that are also working on housing issues. States officials also mentioned setting aside rental vouchers for MFP participants transitioning back to the community, and identifying current or future rental projects that offer affordable units for MFP participants.

As of August 2011, nineteen states employed housing coordinators that assist individuals interested in transitioning to secure housing. Michigan utilizes twenty housing coordinators around the state that help find housing for nursing home residents who wish to transition to the community. Other state examples to improve housing options are listed below:

- **Illinois** is looking to improve coordination between the Department of Healthcare and Family Services (the state Medicaid agency) and the Illinois Housing Development Authority (IHDA) with the goal of developing a single entity that is responsible for coordination of housing resources across disability populations.
- **New Jersey** is partnering with housing authorities, real estate and housing developers, and utilizing rental assistance vouchers, a "real time" housing resource database and a housing specialist to coordinate resources.
- **Ohio** operates a Medicaid/Housing workgroup that meets regularly in addition to partnerships with housing authorities that help to secure HUD type II housing vouchers.
- **North Carolina** is working to provide MFP participants a list of potential community roommate options along with adequate subsidized housing options.
- **North Dakota** has established a statewide housing alliance that brings all housing agencies together to address needed development and planning.
- **New Mexico** has plans to include MFP participants in a statewide database of public housing authorities. The database tracks Section 8 Housing Choice Voucher waiting lists and targets population preferences to increase access to subsidized housing for individuals with disabilities.

Half of MFP states reported an inadequate supply of direct care workers in the community. Community workforce shortages impact the availability of community-based services, and therefore states are working to strengthen direct support networks to ensure successful transitions home. Rural areas are particularly vulnerable to workforce shortages. Many states are actively engaged in expanding the direct support workforce. Most efforts are intended to strengthen the capacities of direct support professionals and elevate their standing as professionals (re: compensation, benefits and authority). Examples of workforce strategies adopted by states include: a direct care service registry website, encouragement of Medicaid beneficiaries to hire family caregivers through the consumer directed option, online training programs that provide education and competency-based training curricula.

- **Louisiana** is utilizing 100 percent administrative funding in support of its MFP demonstration to develop and deliver direct support workforce training that offers workers a specialization training program in the support of persons with intensive needs transitioning from institutions.
- **New Jersey** has purchased the College of Direct Support to provide continuing education and training opportunities that will: foster an increase in the quality of services being delivered, reduce turnover and improve professionalism of direct support workers.

Current efforts focus on training for those working with the developmentally disabled population with future plans to include training with the elderly.

Three-quarters of states reported no adverse impact on MFP due to the current fiscal environment. Because the MFP program is a demonstration grant, funding is guaranteed once a state gets approval of its operational protocol. Only six states reported experiencing a direct impact on the MFP demonstration due to the current economic environment. However, several states pointed to indirect impacts of the poor economy such as reductions in Medicaid provider payment rates and waiver services as challenging to MFP. Other states mentioned hiring freezes and furloughs as having a negative impact on MFP implementation and overall state long-term services and supports rebalancing efforts.

Twenty-eight MFP states are planning to take up at least one of several new ACA options to expand Medicaid home and community-based services. As mentioned earlier, 13 additional states applied and received funding to implement MFP demonstrations when the program was extended an additional five years. Compared to last year when only a handful of states reported actively exploring ACA options related to long-term services and supports, this year's survey found greater interest in some or all of the following: Community First Choice, State Balancing Incentive Payments Program, HCBS state plan option (1915(i)), and the Health Home option. While some states are still waiting for guidance on these options, others are moving ahead with plans to implement them. The most popular new option reported was the Health Home option (17 states) for the chronically ill that offers a new approach to manage care. States also reported interest in the State Balancing Incentive Payments Program that provides enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services for five years starting in October 2011.

Housing and workforce capacity are among the major challenges facing MFP demonstrations in the year ahead. Expanding the scope of housing opportunities continues to be the main challenge facing states today. Almost all states mentioned the ongoing challenge of finding safe, affordable, and accessible housing options for MFP participants. States highlighted the need for additional funding assistance related to housing noting that long wait lists for subsidized housing vouchers often delay transitions. Another challenge related to recruitment of direct service workers in community-based settings, especially in rural areas. Some states have specific outreach and marketing strategies to increase the number of community-based providers, but recruitment continues to be a concern. State officials also pointed to the impact of budget pressures, both in terms of funding for ongoing services as well as funding necessary to expand MFP to reach more people currently residing in institutional settings, as hurdles facing MFP. Several new grantee states highlighted issues related to setting up their MFP program in a fiscally difficult environment, including the ability to secure MFP staff in a timely manner. Other challenges mentioned include the MFP requirement of a "qualified residence" as a barrier to transition, since it can be difficult to locate group housing with less than four people for individuals with disabilities, and the difficulty associated with transitioning people with multiple chronic health conditions, including both behavioral and physical disabilities.

One factor that was reported for the first time since this survey began in 2008 was the challenge of keeping individuals in the community once they have transitioned. Ensuring sustainability for participants in the community, particularly those individuals not enrolled on a HCBS waiver,

was a priority for MFP programs. MFP officials also highlighted the importance of continually focusing on family supports to keep participants in the community once transition has occurred.

CONCLUSION

Over the past three years, states have transitioned a cumulative total of nearly 17,000 individuals with disabilities and seniors out of institutional settings and back home to the community. Although it took states several years to get their MFP demonstration programs up and running, 2011 marked a turning point for MFP. In the ACA, MFP eligibility was modified and funding was extended an additional five years. In early 2011, thirteen new states took advantage of this opportunity and applied and received funding to begin MFP demonstrations (or to submit their operational protocols). Today, a total of 44 states have received funding to transition people out of institutional settings through MFP.

As states embrace rebalancing their long-term services and supports delivery systems, MFP will remain a critical program helping to change the way long-term services and supports are delivered. The goal of MFP is to serve individuals with long-term service and supports needs in a safe, more cost-effective setting and one in which individuals can retain independence and freedom. With the help of critical services such as transition coordination, assistive technology, transportation and affordable housing options, many more people will benefit from MFP in the years ahead. However, as more Medicaid beneficiaries are identified to transition to the community, and as the population continues to age, more community-based workers will be needed to assist them and additional housing options will be needed to help facilitate successful transition.

This brief was prepared by Molly O'Malley Watts, Principal of Watts Health Policy Consulting, for the Kaiser Commission on Medicaid and the Uninsured.

THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

MONEY FOLLOWS THE PERSON DEMONSTRATION: A 2011 SNAPSHOT

The Kaiser Commission on Medicaid and the Uninsured (KCMU) is conducting a short survey of state MFP demonstrations. This is the third KCMU survey conducted since 2008 that seeks to highlight recent state experiences and trends in Medicaid home and community-based services. Once again, we are requesting your assistance in completing the following survey. Questions regarding the survey can be directed to Molly O'Malley Watts (703) 371-8596 or Jhamirah Howard (202) 347-5270.

Please return completed surveys by SEPTEMBER 1st to: momalley8@gmail.com

1. Money Follows the Person Program Status

a. Is your program operational? ☐ Yes ☐ No
b. If no, why not and when do you intend to be operational? _____

2. Money Follows the Person Demonstration Services

Please list the key services that make up your MFP demonstration. Please be as specific as possible.

HCBS Qualified Services (including HCBS state plan and waiver services)	Demonstration Services	Supplemental Services (one-time services or limited duration services)

3. Money Follows the Person Transitions by Population

	Total	Seniors	Physical Disability	Developmental Disability	Mental Illness	Dual Eligible
Transitions Completed						
Transitions in Progress						
Rate of Reinstitutionalization						
Average age of MFP participants						
Average length of time to transition to community						
Housing option most likely to transition to						

a. Is your program on pace with annual transition targets? ☐ Yes ☐ No

b. If no, please describe reasons for delay in meeting transition goals.

_____

c. Is your state trying to increase transitions among the mentally ill? ☐ Yes ☐ No ☐ Don't Know

d. If yes, please describe efforts to increase services and outreach to this population.

_____

4. Money Follows the Person and Self-Direction

a. Does your program offer self-directed options to MFP participants? ☐ Yes ☐ No

b. Please estimate the percentage of current MFP participants who self-direct some or all of their own services _____

5. Money Follows the Person Community Housing Options

a. Please describe what you believe are the *key factors* to providing safe, affordable and accessible housing options for MFP participants (i.e., partnerships with housing authorities or other state/community groups): _____

_____

b. Do you employ a housing coordinator within MFP to help with transitions? ☐ Yes ☐ No

6. Average Monthly Cost of Serving a MFP Participant by Population

	Total	Seniors	Physical Disability	Developmental Disability	Mental Illness	Dual Eligibles
Average Cost						

a. Compared to costs for institutional beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

b. Compared to costs for other HCBS beneficiaries is this cost ☐ higher ☐ comparable ☐ lower?

7. Community Workforce

a. Does your state have an adequate supply of direct service workers? ☐ Yes ☐ No

b. Please describe strategies to address workforce issues: _____

8. Health Reform Opportunities

a. Is your state actively exploring any of the following ACA options (*check all that apply*):

LTSS State Option	Yes/No
Community First Choice	
State Balancing Incentive Program	
HCBS state plan option	
Health Home option	

Comments on how your MFP demonstration works in conjunction with other HCBS programs or health reform options: _____

b. Is your state partnering with Aging and Disability Resource Centers (ADRCs) to help identify participants? ☐ Yes ☐ No Comments: _____

9. Impact of the Economic Downturn

Has your MFP demonstration had to make any changes or cutbacks due to fiscal concerns (i.e., limiting enrollment, reducing services, etc.)? If so, please describe: _____

☐ Yes ☐ Possibly Yes ☐ Not Likely ☐ No ☐ Don't know

10. Future Outlook

What are the most significant issues or challenges facing MFP in the coming year or two?

_____

_____

Thank you for your participation in this survey.

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